CEL TEN FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155159	B. WING		02/17/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R			
OLINANAIT	OLTY ALLIDOUNG A	ND DELIADII ITATION		CLINTON ST	
SUMMIT	CITY NURSING A	ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was	for a Recertification and	F0000	The creation and submission	of I
			10000	this plan of correction does no	
	State Licensure Survey.			constitute an admission by thi	
				provider of any conclusion set	
	Survey dates:	February 13, 14, 15,		forth in the statement of	'
	16, and 17, 20	-		defciencies, or of any violation	n of
				regulation.This provider	
	Facility number	or: 000070		respectfully requests that the	
	,			2567 plan of correction be	
	Provider number: 155159			considered the letter of credib	le
	AIM number: 100266160			allegation and request a post	
				survey review on or after 3-18	-12.
	Survey team:				
	Rick Blain, RN	L TC			
	-				
	Sue Brooker, I				
	Diane Nilson,				
	Angela Strass	, RN			
	Census bed ty	me.			
	SNF/NF: 46	рс.			
	Total: 46				
	Census payor	type:			
	Medicare: 3				
	Medicaid: 34				
	Other: 9				
	Total: 46				
	Stage 2 sampl	le: 27			
	These deficien	ncies reflect state			
		n accordance with 410			
	_	ii accordance with 410			
	IAC 16.2.				
	Quality review	completed on February			
	Ī		1		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 17/2012
NAME OF P	PROVIDER OR SUPPLIEF	- !		ADDRESS, CITY, STATE, ZIP (CLINTON ST	CODE	
SUMMIT	CITY NURSING A	ND REHABILITATION		WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	22, 2012 by Be	ev Faulkner, RN				

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Event ID: SXTS11

Facility ID: 000079

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159 NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO156 483.10(b)(5) - (10), 483.10(b)(1) SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the	STATEMENT OF DEFICIENCI	CIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO156 SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE O2/17/2012	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO156 SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		155159			02/17/2012
SUMMIT CITY NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO156 483.10(b)(5) - (10), 483.10(b)(1) SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both 2940 N CLINTON ST FORT WAYNE, IN 46805 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG OMPLETION DATE				ADDRESS CITY STATE ZIR CODE	<u> </u>
SUMMIT CITY NURSING AND REHABILITATION FORT WAYNE, IN 46805 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO156 SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both FORT WAYNE, IN 46805 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both	NAME OF PROVIDER OR SUP	JPPLIER			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FO156 483.10(b)(5) - (10), 483.10(b)(1) SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION TAG TAG THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY) DATE	CLIMMIT CITY NUIDCIN	NO AND DELIADILITATION			
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOTIGE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG COMPLETION TAG COMPLETION DATE COMPLETION DATE FOOTIGE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION DATE	SUMMIT CITT NURSIN	NG AND REHABILITATION	FORT	WATNE, IN 40005	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FO156 SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION TAG TAG TAG TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY) DATE	(X4) ID SUMMA	1ARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F0156 483.10(b)(5) - (10), 483.10(b)(1) SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both	PREFIX (EACH DEF	FICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
SS=B NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both	TAG REGULATOR	ORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
CHARGES The facility must inform the resident both	F0156 483.10(b)(5	5) - (10), 483.10(b)(1)			
The facility must inform the resident both					
I I orally and in writing in a language that the I					
resident understands of his or her rights and		•			
all rules and regulations governing resident conduct and responsibilities during the stay in					
the facility. The facility must also provide the					
resident with the notice (if any) of the State		•			
developed under §1919(e)(6) of the Act.		The state of the s			
Such notification must be made prior to or					
upon admission and during the resident's		-			
stay. Receipt of such information, and any					
amendments to it, must be acknowledged in	amendment	nts to it, must be acknowledged in			
writing.	writing.				
The facility must inform each resident who is					
entitled to Medicaid benefits, in writing, at the					
time of admission to the nursing facility or,					
when the resident becomes eligible for Medicaid of the items and services that are		•			
included in nursing facility services under the					
State plan and for which the resident may not					
be charged; those other items and services					
that the facility offers and for which the					
resident may be charged, and the amount of		-			
charges for those services; and inform each		· ·			
resident when changes are made to the items	resident who	hen changes are made to the items			
and services specified in paragraphs (5)(i)(A)					
and (B) of this section.	and (B) of th	this section.			
The facility must inform each resident before,					
or at the time of admission, and periodically					
during the resident's stay, of services					
available in the facility and of charges for those services, including any charges for					
services not covered under Medicare or by					
the facility's per diem rate.					
and table of the factor of the	and radility 3	- p-: 3:0::: 14:0:			
The facility must furnish a written description	The facility	must furnish a written description			
of legal rights which includes:					

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Event ID: SXTS11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIG	00	COMPL	ETED
		155159	A. BUIL B. WINC			02/17/	/2012
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEI	₹			CLINTON ST		
CLIMMIT	CITY NI IDSING A	ND REHABILITATION			VAYNE, IN 46805		
					VATIVE, IIV 40005		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	•	the manner of protecting under paragraph (c) of this					
	procedures for ed Medicaid, included assessment und determines the ed non-exempt rescinstitutionalization community spouresources which available for payinstitutionalized or her process of eligibility levels. A posting of name telephone number of the Medicaid of the process	the requirements and establishing eligibility for ing the right to request an ler section 1924(c) which extent of a couple's purces at the time of an and attributes to the use an equitable share of a cannot be considered ement toward the cost of the spouse's medical care in his of spending down to Medicaid mes, addresses, and ers of all pertinent State					
	survey and certi- licensure office, program, the pro- network, and the and a statement complaint with the certification age- abuse, neglect, resident property	groups such as the State fication agency, the State the State ombudsman official and advocacy e Medicaid fraud control unit; that the resident may file a ne State survey and ncy concerning resident and misappropriation of y in the facility, and with the advance directives					
	requirements sp 489 of this chap written policies a advance directiv include provision written informati concerning the r	e comply with the ecified in subpart I of part ter related to maintaining and procedures regarding res. These requirements as to inform and provide on to all adult residents ight to accept or refuse cal treatment and, at the					

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Event ID: SXTS11

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155159	B. WIN			02/17/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER			2940 N	CLINTON ST		
	CITY NURSING AI	ND REHABILITATION	_		WAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		n, formulate an advance	+	TAG	BLI TELLICET (DATE
	directive. This in	ncludes a written description olicies to implement advance					
		pplicable State law.					
	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.						
		prominently display in the					
		formation, and provide to oplicants for admission oral					
	·	mation about how to apply for					
	and use Medicare and Medicaid benefits, and how to receive refunds for previous payments						
	covered by such	benefits.	EOI	<i>5 (</i>		4	02/19/2012
			F01	36	It is the intent of this communito inform residents and family	ty	03/18/2012
	Based on reco				members of their rights both		
		acility failed to provide			orally and in written format. He	ow	
		indicating two days			will you identify other reside	nts	
		vided regarding			having the potential to be		
		are non-coverage for 2			affected by the same deficient practice and what corrective		
		(Resident #42 and			action will be taken?The IDT		
	Resident #47)				team will review and discuss		
	notification of N	vledicare			daily during morning meeting	all	
	non-coverage.				residents pending notifications		
					What measures will be put ir	1	
	Findings includ	le:			place or what systemic changes will you make to		
	0.04-4-				ensure that the deficient		
		2:00 P.M., three			practice does not recur? A		
		licare Non-Coverage			mandatory in-service for all		
	were received	and reviewed.			management team members		
					be conducted on or before Ma		
		f Medicare Provider			16, 2012. This in-service will to conducted by the SS consultation.		
	_	" form for Resident #42			order to ensure proper direction		
	indicated "The				of notification guidelines. This		
	coverage of yo	ur current outpatient			verification process will esure	that	
					all proper notifications will be	in	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	ETED
		155159	B. WING	NU		02/17/	2012
				TREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION			VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	T.	AG	DEFICIENCY)		DATE
	rehabilitation s	services will end:			place before the changes of		
	October 7, 20	11."			services. The medical records		
	,				personnel will verify that all pa	per	
	The form indic	ated Resident #42			work is completed in a timely fashion in compliance. How w	/ill	
		ted the form on			the corrective action be	****	
	•	ating she had received			monitored to ensure the		
	the notice on t	•			deficient practice will not rec	ur	
		nai dale.			and what quality assurance		
	2 A "Ninting	of Medicare Provider			program will be put in place?	•	
					The IDT team will		
	_	e" form for Resident #47			monitor resident notifications of	on a	
	indicated "The				a daily basis to identify the		
	,	our current outpatient			potential for deficient practices To ensure compliance, the	3.	
	rehabilitation services will end:				Executive Director/designee w	rill	
	September, 30), 2011."			be responsible for completion		
					the CQI tool weekly x 4 weeks		
	A handwritten	note on the back of the			bimonthly times 2 months, and		
	form indicated	the resident's Power of			then quarterly until compliance	e is	
		a) had received notice of			maintained for 2 consecutive		
	• •	age on 9/30/11 by			quarters. The results will be		
		had signed the form			reviewed by CQI committee overseen by the ED. If thresho	ıld	
	on 10/3/11.	riad signed the form			of 95% is not achieved an active		
	011 10/3/11.				plan will be developed to ensu		
	The feetitule 5	ive outive Director (CD)			compliance.	-	
	1	executive Director (ED)			•		
		ed on 2/16/12 at 10:15					
		e interview, the ED					
		acility did not have a					
	, , ,	ng the provision of the					
	"Notice of Med	dicare Non-Coverage"					
	information to	residents or their					
	POA's, but the	e facility followed the					
	regulations an	d a minimum of two					
	•	ould have been					
	provided.						
	3.1-4(f)(3)						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CO	00 	CON	TE SURVEY MPLETED 17/2012			
	ROVIDER OR SUPPLIE		B. WING CONTINUE STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		

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Event ID: SXTS11

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		A. BUILDING 00 COMPI B. WING 02/17		(X3) DATE S COMPL 02/17 /	ETED	
	ROVIDER OR SUPPLIER	ND REHABILITATION		2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0252 SS=D	483.15(h)(1) SAFE/CLEAN/C ENVIRONMENT The facility must comfortable and allowing the residence personal belonging Based on obsevere and review, ensure a wheeled was free from the residents who revised in continence in 27 residents (Residents and residents who residents who residents who residents who resident wheeled to the resident up, the pants were sate wheeled air was wet area on it.	provide a safe, clean, homelike environment, dent to use his or her ngs to the extent possible. rvation, interview, and the facility failed to Ichair pressure pad odor for 1 of 2 met the criteria for a stage 2 sample of tesident #27). e: 7 was observed sitting, in her room, at 2:40 2. A puddle of a liquid was noted on the wheelchair. Two di #20, indicated they provide incontinence dent, who they seen incontinent. CNAs stood the back of the resident's trated and the in the resident's a noted to have a soiled In interview, CNA #20 esident had been	F02		What corrective actions will I accomplished for those residents found to have been affected by the deficient practice? The chair belonging Resident #27 was cleaned immediately to include the wheelchair cushion. All wheelchairs and cushions we cleaned immediately and then daily according to wheelchair cleaning schedule. WC and WC cushion cleaning schedule implemented on 3rd shift and a clinical nursing staff educated importance of ensuring cleanliness of adaptive equipment. How will you ident other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents that transposite with wheelchairs have the potential for soiled cushions accompanied by odor. Clinical nursing staff will identify such potential by cleaning wheelchait by schedule and as needed. A Post test will be given to assess understanding. What measure will be put in place or what systemic changes will you make to ensure that the	to re Clall on cify e cort	03/18/2012

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Event ID: SXTS11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLET	TED
		155159	B. WIN	NG		02/17/20	012
NAME OF I	DDOMDED OD CHIDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE			2940 N	CLINTON ST		
	1	ND REHABILITATION			VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
		#27's record was			deficient practice does not recur? DNS/designee will		
reviewed on the morning of 2/16/12.					in-service all nursing staff on \	NC.	
		Data Set assessment,			cleaning. 3rd shift staff will foll		
	dated 11/28/11	, indicated the resident			wheel chair cleaning schedule		
	was cognitively	/ impaired, with short			due to most/all residents are i		
	and long term	memory impairment,			bed during this period. If resid		
	required extens	sive to total assistance			are awake and transporting vi		
	with activities of	of daily living care, and			wheelchairs, additional cushio		
		it of bowel and bladder.			are available until cushions ar dry and ready for use. Charge		
					nurses will monitor wheelchair		
	On 2/16/12 at	9:35 A.M., a urine odor			cleaning for compliance		
		ne resident's room, and			daily.How will the corrective		
		ad in the resident's			action be monitored to ensu	re	
		s noted to have an odor			that the deficient practice wi	ll	
		s noted to have an oddi			not recur? 3rd shift nurses an	-	
	of urine.				certified nursing assistants wil		
		into the resident's			sign wheelchair cleaning shee daily and turn in with 24 hour	rts	
		irmed the pad in the			report. Logs will be monitored	5ys	
	wheelchair ha	d an odor.			a week DNS/designee will	UAS	
					monitor the wheelchair CQI lo	g	
	On 2/16/12, at	9:57 A.M., Physical			daily x 1 month, twice weekly		
	Therapy Assist	tant #23 was observed			months, and weekly x3 month		
	placing a new	pad in the wheelchair			ending with quarterly checks		
	and in interviev	w indicated LPN #22			compliance is maintained for t		
	had requested	a new pad.			consecutive quarters. A post t will be given to check for	esi	
		•			understanding.Data will be		
	Review of the	3rd shift duties form,			submitted to CQI committee for	or	
		e Assistant Director of			review and follow up on a mor	nthly	
		es, on 2/16/12 at 12:16			basis until compliance. A		
		wheelchairs and			compliance threshold of 95%		
		to be deep cleaned			be used to determine continue		
					monitoring and an action plan be developed to ensure	vvIII	
	every Thursday	у.			compliance. Non compliance	_{mav}	
	0.4.40(5(5)				result in disciplinary action up		
	3.1-19(f)(5)				and including termination.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155159	A. BUILDING B. WING	00	COMPLETED 02/17/2012	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE CLINTON ST		
SUMMIT	CITY NURSING AN	ND REHABILITATION		VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	

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Event ID: SXTS11

Facility ID: 000079

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155159	B. WIN			02/17/	2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .			CLINTON ST		
CHAMAIT	CITY NI IDRING AN	ND REHABILITATION			WAYNE, IN 46805		
SOMMIT	CITT NORSING AI	ND REHABILITATION		FORT	WATNE, IN 40805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309	483.25						
SS=D	-	E/SERVICES FOR HIGHEST					
	WELL BEING						
	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and						
			F0309		What corrective actions will be		03/18/2012
		•	1 00		accomplished for those		05/10/2012
		the facility failed to			residents found to have been	1	
		ure 2 of 3 residents			affected by the deficient	-	
	•	rved (Resident #26			practice? Residents #26 and	#14	
	and Resident #	414) during dining were			were re-evaluated by therapy		
	positioned safe	ely in the Stage 2			services for accurate positioning	ng	
	sample of 27.				for feeding to ensure resident's	S	
	'				safety. Resident #26 now able	to	
	Findings includ	۵.			withstand a higher degree of		
		C.			positioning and clinical nursing		
	1 Review of th	e clinical record for			staff now aware of positioning.		
		on 2/15/12 at 3:00 p.m.,			New adjustable tables have be purchased. Resident #14 is	een	
		•			seated at adjustable table in		
		ollowing: diagnoses			custom-fitted wheelchair speci	fic	
		ere not limited to,			to resident's statute. A regular		
	organic psycho				chair is not specific to her statu		
	dementia with p	psychotic/agitated			and therefore resident will rem		
	features, depre	ession, Alzheimer's			in wheelchair during dining		
	dementia, seizi	ures, and Picks			services. Both Resident's care	:	
	disease.	,			plan and CNA assignment		
					guides have been updated to		
	Nursing Progra	ess Notes for Resident			reflect the residents current		
					status. How will you identify		
	,	2/12, indicated he was			other residents having the potential to be affected by the	•	
		ocal hospital with a			same deficient practice and	C	
	fractured left hi	p.			what corrective action will be	,	
					taken? All residents with	•	
	Nursing Progre	ess Notes for Resident			decreased ROM, muscular		
		7/12, indicated he was			rigidity, and decreased sitting		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155159	A. BUII B. WIN	LDING		02/17/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CLIMANAIT	CITY NUIDOING A	ND REHABILITATION			CLINTON ST WAYNE, IN 46805		
SUMMINI	CITT NURSING AI	ND REHABILITATION		FURI	/VATINE, IN 40005		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	re-admitted to	the facility.			tolerance are assessed for sa	•	
					while dining. All staff re-educa		
	A physician's o	order for Resident #26,			to identify risk factors association with residents with decreased	iea	
	dated 1/27/12, indicated for Speech				ROM and rigidity with postura	I	
	Therapy to evaluate and treat.				disturbances by	•	
	Thorapy to evaluate and treat.				DNS/designee.What measure	es	
	A physician's order for Resident #26,				will be put in place or what		
					systemic changes will you		
	dated 1/28/12,				make to ensure that the		
		speech therapy order.			deficient practice does not		
	The physician's order indicated				recur? All Staff including clinic	cal	
	speech therapy	was not indicated at			staff and department manage	rs	
	this time.				will be re-educated by		
					DNS/designee via in-services		
	A physician's o	order for Resident #26,			proper assessment of residen		
		indicated physical			at risk for safety hazards relat to positioning while eating. All	-	
		uate and treat as			Staff members to observe for		
		physician's order also			tilted head or improper posturi	ina	
					during dining services. Staff to		
		cal therapy to receive			alert DNS/designee and/or		
		I therapy services 5			therapy services immediately	if	
		er week) x 8 wks.			risks exist that may impair saf		
	Treatment may	include therapy			while eating. Charge nurses w	/ill	
	activities, neuro	o-muscular			immediately correct improper		
	re-education, p	ain management, and			positioning demonstrated duri	-	
	caregiver/staff	training as needed.			dining services.Manager in DF during meal times will monitor		
		J			improper positioning and refer		
	A Therany Car	e Plan for Resident			DNS and/or Manager of Thera		
		rt date of 1/28/12,			services. Therapy manager w		
		roblem areas of			communicate daily on any		
					therapy issues or current		
		, decreased bed			treatment that may influence		
	_	ased left hip ROM			nursing care. How will the		
	(range of motion	on), and decreased			corrective action be monitor		
	sitting tolerance	e. Goals to the			to ensure the deficient pract		
	problems inclu	ded, but were not			will not recur and what quali	-	
	limited to, be a	ble to sit up in			assurance program will be p		
	· ·	2-3 hours without			in place? A CQI meal service		
			1		observation Log will be monitor	n e u	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155159	B. WIN			02/17/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION			VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pain/discomfor	t.			daily x 1 month, twice weekly		
					months, and weekly x3 month		
	A Physical The	erapy Plan of Treatment			and then quarterly until continu		
	_	26, with an onset date			compliance is maintained for 2	2	
		icated he exhibited			consecutive quarters by DNS/designee. Data will be		
	· ·				submitted to CQI committee for	or	
	1 .	stiffness and pain while			review and follow- up on mont		
	· ·	5 degrees in the			basis. The results of these aud	•	
	cardiac chair fo	or 30 minutes.			will be reviewed by the CQI		
					committee overseen by the EI) .	
		erapy Progress Report			Noncompliance may result in		
	for Resident #2	26, dated 1/28/12 -			disciplinary actions.DNS/desig		
	2/3/12, indicate	ed he exhibited			will be responsible for program		
	hypertonicity, s	stiffness and pain while			compliance. If threshold of 95° not achieved an action plan wi		
		0 degrees in the			be developed to ensure	III	
	cardiac chair fo	_			compliance.		
		or do minutos.					
	Δ Physical The	erapy Progress Report					
		26, dated 2/4/12 -					
	•	ted he exhibited					
	1 .	stiffness and pain while					
	-	0 degrees while seated					
	in the cardiac of	chair for 2 hours.					
	A facility care p	olan for Resident #26,					
	with a start dat	e of 2/6/12, indicated					
	the problem ar	ea of self care deficit					
		eimer's dementia and					
		ture. Approaches to					
	=	cluded, but were not					
		iac chair when up and					
		iac chair when up and					
	fed per staff.						
	A physician's order for Resident #26						
	A physician's order for Resident #26, dated 1/31/12, indicated a Regular						
		indicated a Regular					
	Diet.						

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Event ID: SXTS11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		155159	B. WING			02/17/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
CLIMANAIT	CITY NUIDOING A	ND DELIABILITATION			CLINTON ST		
		ND REHABILITATION			VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OF	CESC IDENTIF TING INFORMATION)		IAG	,		DATE
	During an obse	ervation of the lunch					
		cond floor dining room					
		12:25 p.m., Resident					
		ved in the dining room					
		approximately 30					
		horizontal with his					
	_	tended to the back in					
		air. CNA (Certified					
		ant) #9 was observed					
		veral bites of food with					
	Resident #26 i	n this position before					
	raising his card	diac chair to					
	approximately	60 degrees above					
	horizontal. His	neck remained					
	hyper-extende	d toward the back of					
	the chair as CN	NA #9 continued to					
	feed him his lu	nch meal.					
	During an obse	ervation of the lunch					
	_	cond floor dining room					
		12:10 p.m., Resident					
		ved in the dining room					
		approximately 30					
		horizontal with a pillow					
	_	d in his cardiac chair.					
		observed to give him					
		f food with Resident					
	#26 in this pos	ition before raising his					
	-	o approximately 60					
	degrees above	horizontal. His head					
	remained reclin	ned with his mouth					
	facing toward t	he ceiling. CNA #10					
	was then obse	rved to offer him a					
	glass of juice b	by bringing the full glass					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155159	B. WIN			02/17/	2012
NAME OF B	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		2940 N	CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION		FORT V	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
		ith his head still tilted					
		n was observed to put					
		glass and offer him a					
		0 continued feeding					
		by placing his eating					
		mouth at an angle					
	toward the bac	k of his throat.					
	During an obse	ervation of the					
	_	on 2/16/12 at 8:25					
	a.m Resident	#26 was observed					
	•	NA #11 in his bed. His					
		ed approximately 45					
		horizontal with his					
	•	oward the ceiling. CNA					
		ved standing to feed					
		CNA #11 continued					
		ent #26 by placing his					
		nto his mouth at an					
	_	ne back of his throat.					
	angle toward ti	ic back of fils tilloat.					
	During an obse	ervation of the lunch					
	meal in the sec	cond floor dining room					
	on 2/16/12 at	12:15 p.m., Resident					
	#26 was obser	ved in the second floor					
	dining room re	clined back					
	approximately	30 degrees above					
		a pillow behind his					
		diac chair. CNA #12					
	was observed	to raise his cardiac					
	chair to approx	imately 45 degrees					
		al. His head remained					
		is mouth facing toward					
		e was standing on his					
		ed him by reaching					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155159	B. WING		02/17/2012
NAME OF T	DROLUDED OF CLUBS			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	K	2940 N	N CLINTON ST	
	CITY NURSING A	ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	NATE COM ELTION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	BELLEER	DATE
	_	er hand over his			
		£12 continued feeding			
		by placing his eating			
		mouth at an angle			
	toward the bac	ck of his throat.			
	D				
	Physical Thera	•			
		2/16/12 at 1:50 p.m.			
		rview he indicated			
		ot been asked to			
		nt #26's positioning			
		He also indicated			
		s muscles were			
	becoming hype	ertonic and at times his			
	natural posture	e was to hold his head			
	back. He furth	er indicated 45			
	degrees was th	ne minimum posture			
	recommended	, but he was safe to be			
	at 75 degrees.	Resident 26's posture			
	could be more	upright if staff elevated			
	him slowly.				
	Speech Therap				
		2/16/12 at 4:15 p.m.			
		rview, she indicated			
		ceived a request from			
	1	ssess the safety of			
		during dining since he			
	had been sittin	g in the cardiac chair			
	for meals inste	ad of a regular dining			
	chair. She also	o indicated she had			
	observed Resident #26 and wondered how he managed to eat				
		head tilted so far back.			
		licated residents should			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO LDING	nstruction 00	· ·	TE SURVEY IPLETED	
		155159	B. WIN			02/	17/2012
NAME OF PROVIDER OR S		ND REHABILITATION		2940 N	ADDRESS, CITY, STATE, ZIP CO CLINTON ST VAYNE, IN 46805	DDE .	
PREFIX (EACH D TAG REGULAT	EFICIEN ORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
RN #17 w 10:05 a.m indicated communicated communicated communicated and residen LPN #7 w on 10:40 she indicated by the communicated by the communicated by state and the communicated by state and the communicated by state and the communicated appropriated for a communicated fo	vas in thera cate vas in thera cate vas in a.m. cated (aursin e what a cuent #2 f Nur be presented facilities as in as in a ted to a cated the cat	terviewed on 2/17/12 at ring the interview, she py was to with nursing concerning dations or changes for terviewed on 2/17/12 During the interview, CNA care sheets were g personnel to t each resident rrent CNA care sheet 26, provided by the sing on 2/17/12 at licated he was to be t did not indicate how ositioned in his cardiac cypolicy "Morning ed 6/10, indicated I pertinent facility a team to ensure low-up and continuity to be reviewed at ng:24 hour condition terviewed on 2/17/12 During the interview, he morning meeting scuss significant					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	nstruction 00	(X3) DATE S COMPLI		
		155159	B. WIN			02/17/	2012
	PROVIDER OR SUPPLIER	ND REHABILITATION	•	2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
PREFIX TAG	changes and the residents and of disciplines shot assessments/ref. 2. Review of the Resident #14 of indicated the foliocated the foliocated the foliocated part of disease, decrethistory of depresident #14 of a dining an obsermed on 2/13/1 Resident #14 of a dining table in dining room early had been transpediatric wheeld dining chair. Defining chair. Defining chair.	ne progress of determine what uld be involved in e-assessments. e clinical record for on 2/15/12 at 2:12 p.m., ollowing: diagnoses were not limited to, yndrome, Alzheimer's ased appetite, and		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	floor without ar feet to stabilize was not touching and she was of into the table. During an observation of the second a.m., Resident sitting at a dining floor dining roo	ny support under her her posture. Her back ng the back of the chair bserved to be leaning					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155159	B. WIN	G		02/17/	2012
NAME OF F	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
	OLTY AND IDOUNG AN	UD DELIABILITATION			CLINTON ST		
SUMMIT	CITY NURSING AI	ND REHABILITATION		FORTV	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· •	chair into a regular					
		ue to her short stature					
		bserved dangling 2 inches above the					
	l · · ·	ny support under her					
		her posture. Her back					
		ng the back of the chair					
		bserved to be leaning					
	into the table.	occired to be learning					
	During an obse	ervation of the lunch					
		2 at 12:00 p.m.,					
		vas observed sitting at					
		n the second floor					
		ting her breakfast.					
		transferred from her					
	pediatric wheel	chair into a regular					
	l ·	ue to her short stature					
	her feet were o	bserved dangling					
	approximately	2 inches above the					
	floor without ar	ny support under her					
	feet to stabilize	her posture. Her back					
	was not touchir	ng the back of the chair					
		bserved to be leaning					
	into the table.						
		ervation of the lunch					
		2 at 12:05 p.m.,					
		vas observed sitting at					
		n the second floor					
	_	ting her breakfast.					
		transferred from her					
	I -	chair into a regular					
		ue to her short stature					
	ner teet were o	bserved dangling					

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Event ID: SXTS11

Facility ID: 000079

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155159	A. BUILI		00	COMPLE 02/17/2	
		.55100	B. WING	_	DDRESS, CITY, STATE, ZIP CODE	52/11/2	
NAME OF F	PROVIDER OR SUPPLIER				CLINTON ST		
SUMMIT	CITY NURSING AN	ND REHABILITATION			/AYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	approximately:	2 inches above the					
	floor without ar	y support under her					
		her posture. Her back					
		ng the back of the chair					
		oserved to be leaning					
	into the table.						
	Certified Occur	pational Therapy					
		as interviewed on					
	2/16/12 at 1:58	p.m. She indicated					
	Resident #14 h	•					
		to her small stature.					
		ited her feet touched en she was in her					
	_	support should be					
		at the dining table. She					
		d therapy received					
		he nursing department					
	to evaluate a re	esident for positioning.					
	A current facilit	y policy "Meal Service					
		n", revised on 4/11,					
	indicated "Dir	ning room tables					
		juate in height to					
	accommodate						
	a resident's fee	policy did not indicate					
		ort to maintain posture.					
	2.4.27(-)						
	3.1-37(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) M A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE S COMPL 02/17/	ETED	
	ROVIDER OR SUPPLIER	ND REHABILITATION		2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΕ	(X5) COMPLETION DATE
F0314 SS=G	PRESSURE SO Based on the co a resident, the faresident who ent pressure sores of sores unless the demonstrates the and a resident hareceives necessing prevent new sore. Based on obserecord review, prevent the developressure ulcer, open area in the 1 of 1 randomly a stage 2 samp (Resident #2). Findings included 1. Resident #2 11:00 a.m., on she was having stomach, and be receiving pain in hours, which he the resident's he contracted, worse and obserted worse and obserted on 2/13/12, at 12.00 a.m. and the resident's he contracted.	mprehensive assessment of acility must ensure that a ers the facility without loes not develop pressure individual's clinical condition at they were unavoidable; aving pressure sores ary treatment and services to prevent infection and es from developing. rvation, interview, and the facility failed to velopment of a resulting in a painful e palm of the hand for vobserved residents in ole of 27 residents e: a was interviewed, at 2/13/12, and indicated g pain in her hands, buttocks, and was medication every 4 elped "a little." Both of lands were observed to The left hand was erved balled into a fist. splints noted in place.	F03	14	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #2 is receiving proper wound care a splinting care. The resident's ciplan and care guide has been updated to reflect resident's current condition. How will you identify other residents having the potential to be affected by the same deficient practice a what corrective action will be taken? All residents with hand contractures were assessed for risk factors. All residents with hand contractures will be assessed and charted on daily nurses each shift. Resident's ciplan and Certified Nursing Aid care guide plan has been updated to reflect residents current status. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not	nd care ing y nd th	03/18/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155159	B. WIN			02/17/2012	2
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION			VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COM	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	I	DATE
	nurse. The res	ident was lying in her			recur? All licensed nursing sta	ff	
	bed, with the c	all light noted lying on			will be in-serviced by		
	the bed beside	her left hand. The			DNS/designee on proper assessment and documentation		
	resident indica	ted she was not able to			of contractures. Documentation		
	turn on the call	light due to the			will be done daily x 3 months a		
		her hands, and			then resuming a weekly		
		ands "hurt real bad"			assessment as indicated by		
		d to go to the hospital.			policy. A Post test will be giver	1	
		N #40 came into the			during this in-service.		
		n and the resident			Certified Nursing Assistants w	"	
					be in-serviced to educate on proper care and observation o		
	requested pain	medication.			residents with splints. A post to		
					will be given to Certified Nursii		
	_	tion pass, at 9:10 a.m.,			Assistants. An In-service by		
	on 2/15/12, wit	h LPN#1, the LPN was			Therapy to Restorative Aides	on	
	observed pass	ing medications to			splinting care will also be done	: to	
	Resident #2. T	he resident indicated			include a post test. All		
	her left hand hi	urt.			assessments and monitoring to	У	
	Both the reside	ent's hands were noted			nursing staff will include pain control, nail care, and overall A	עט ו	
	to be in fists wi	th the left worse then			care of residents with the		
		dor was noted to both			potential of the same deficient		
	_	s hands. LPN #1			practice. Therapy manager wil		
		e was an odor to the			communicate daily with Nursir		
		ds and the nurse			leaders any current treatment		
		pen the resident's			may influence nursing care. Ho	ow	
					will the corrective action be		
		but could not open			monitored to ensure the deficient practice will not rec		
	them.				and what quality assurance	"	
		ated she had not taken			program will be put in place?	A	
		ident for awhile, as the			Range of Motion CQI Log will		
		een on a different floor,			monitored daily x 1 month, we		
	and moved rec	ently, but indicated the			x 5 months, and then quarterly	· [
	resident used t	o get occupational			until continued compliance is		
	therapy and wo	ore splints on her			maintained for 2 consecutive	_	
	hands. The nui	rse indicated she didn't			quarters by DNS/desgnee.MD	>	
	know how the	CNAS washed the			coordinator to check restorative-aides documentation	_{nn}	
	resident's hand				of application of splints daily	~··	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPLI	ETED
		155159	A. BUII B. WIN	LDING		02/17/2	2012
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
OL IN AN ALT		ND DELIABILITATION			CLINTON ST		
SUMMIT	CITY NURSING AI	ND REHABILITATION		FORTV	VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The resident w	as questioned at this			following the same schedule		
	time, and indic	ated they didn't wash			listed above. DNS/designee w		
	her hands.	•			monitor for compliance.Data w		
					be submitted to CQI committee	9	
	CNA #3 was in	terviewed at 10:30			for review and follow up monthly.The ED will be		
		2, and indicated he			responsible CQI committee		
					audits. If threshold of 95% is n	ot	
	_	e of Resident #2 and			achieved an action plan will be		
		luled for a bath today.			developed to ensure		
		ated it was difficult to			compliance. Non compliance r		
		ent's hands because			result in disciplinary action up	to	
	they were so c	ontracted and the			and including termination.		
	resident couldr	n't open her hands. He					
	indicated the re	esident used to wear a					
	splint of some	kind, but he hadn't					
	_ ·	it lately. While talking					
		the resident called out,					
		and indicated she was					
		and indicated site was					
	having pain.	on 2/15/12 the CNA					
	· ·	on 2/15/12, the CNA					
		esident refused to					
		ne because she was					
	having too mud	ch pain.					
	RN #4 was inte	erviewed at 2:25 p.m.,					
	on 2/15/12, and	d indicated the					
	· ·	been called on the first					
	shift regarding						
	, ,	pain. The RN indicated					
		v how the resident's					
	hands were wa						
		,					
		de was going to talk to					
	· ·	al therapist today					
	about the resid	lent's hands.					
	Restorative CN	IA #5 was Interviewed					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MUI A. BUILD		NSTRUCTION 00	(X3) DATE (COMPL 02/17 /	ETED	
		155159	B. WING			02/17/	2012
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE CLINTON ST		
SUMMIT	CITY NURSING AN	ND REHABILITATION			VAYNE, IN 46805		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the resident's had placed them on left them on for indicated she had resident's hand resident indicated pain. She indicated in little bit ago" resident's hand soon as she to she indicated spain. Restoration the resident's had when she tried	n 2/15/12, and was placing splints on lands everyday, and in the morning and 4 to 6 hours. She lad tried to open the list this morning, but the lied she was having lated she had checked and tried to clean the list with a cloth, but as luched the resident, he was having hand live CNA #5 indicated lands had an odor and to open her hands, the lited they hurt and					
	Restorative CN she would appl resident's hand them by soaking in warm water wher fingers and apply the splint resident was surdone 6 days and done this treatmetabecause the refusing. She in the therapist to she could do an restorative aide	sident had been ndicated she talked to day and asked her if					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155159	A. BUII		00	COMPLETED 02/17/2012
		100100	B. WIN		DDDEGG GITH GTATE TH GOES	02/11/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CLINTON ST	
SUMMIT	CITY NURSING AN	ND REHABILITATION			VAYNE, IN 46805	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		ed to be cleaned, but		TAG	BEHOLIKETY	DATE
		is in a lot of pain. She				
	indicated the nurse had just given the resident pain medication.					
	Review of the r					
		, provided by the				
		e, and reviewed with				
		ce, indicated there				
		entation indicating the				
	-	lints were completed				
	on 2/7/12, 2/11	,				
		esident had refused /14/12 and 2/15/12.				
		aide indicated she				
		e resident's hands on				
		oplied the splints, but				
		d refused treatment on				
	2/14/12 and 2/1	15/12 because the				
	resident was in	too much pain. She				
	indicated she h	ad just talked to the				
	therapist and th	ne nurse today about				
	the resident's re	efusal.				
	Physical Thera	pist #6 was observed				
		s room, at 3:10 p.m.,				
		rking with the resident.				
		e was trying to open				
		nd the reason there				
		the hand was because				
	it was contractu	ured, and hard to				
	clean. He indic	cated the resident				
	complained of	pain in the palm of the				
	· ·	uld be due to a nail				
	pressing on the	e palm of the hand. He				

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 02/17/	ETED
	PROVIDER OR SUPPLIED	R ND REHABILITATION	•	2940 N	DDRESS, CITY, STATE, ZIP CODE CLINTON ST VAYNE, IN 46805	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the resident last including trans indicated the re able to transfe	ad started working with st week with his goal fers, and mobility. He esident previously was r with 1 assist, but now person transfer assist, v.					
	the afternoon of included, but no Alzheimer's Dishemiparesis, F	ecord was reviewed, on of 2/15/12. Diagnoses ot limited to: sease, hemiplegia or Parkinson's Disease, dysphagia, and Manic					
	assessment, de the resident so interview for me and indicated to extensive to to persons for be dressing, eating hygiene, had used impairment bills of urine, and we management procession and the Medication Addication Add	aterally, was incontinent ras on a scheduled pain					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155159	B. WIN	G		02/17/2	2012
NAME OF E	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUFFLIER			2940 N	CLINTON ST		
SUMMIT	CITY NURSING AI	ND REHABILITATION		FORT V	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		be given every 4					
		ed (PRN) for moderate					
	to severe pain.						
	1	2, indicated the PRN					
		d been given at 2:00					
	•	2 for hand pain, and					
		2, for hand pain, and					
	hand and hip p	ain.					
	Review of nurs	ing progress notes					
	indicated the fo	• • •					
		mbnails were trimmed					
		nto resident's palms;					
	_	further documentation					
	,	notes of further nail					
	care)	otes of fartifer fiall					
	· ·	es pain and discomfort					
	to bilateral han	•					
		ident complained of					
		the left arm and					
		bilateral hands, and					
	resident claime						
		is a result of routine					
		n; physician notified of					
	above;	, բ, ວ.ວ.ສ					
	1	3:44 a.m., complained					
		g, pain pill given ,					
	effective after of						
		3:00 a.m., resident					
		pain in bilateral hands,					
		edication given at this					
	time;	salsation given at time					
	•	0:00 a.m., resident					
		medication did not help					
	•	Resident would not					
ı							

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155159	B. WIN	NG		02/17/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
CLINANAIT	CITY NILIDOING AN				CLINTON ST	
		ND REHABILITATION		<u> </u>	VAYNE, IN 46805	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·	+	TAG		DATE
	allow nurse to a	0:15 a.m., notified by				
		n area to resident's left				
		ed open area to center				
	·	nk in color with white				
		d. Resident required				
		couragement to allow				
	I —	open her hand;				
		0:15 a.m., went to				
	resident to asse	•				
		dent would not open				
	hand for asses	·				
		0:30 a.m., physician				
		area to left hand.				
		efusing assessment,				
	but stated pain	•				
		:00 p.m., Resident				
		to wash and dress area				
	on left hand. Di	ry sterile gauze placed				
		nb from irritating area.				
		ŭ				
	Review of a pre	essure sore risk				
	assessment, co	ompleted on 1/16/12,				
	indicated the re	esident did not refuse				
	care, the reside	ent was confused or				
	had memory pr	oblems, no history of				
	pressure sores	, and the resident had				
	impaired or ded	creased mobility,				
		kly skin assessment				
	l •	ed skin assessments				
		d most recently on				
		0/12, with no open				
	areas noted.					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/17/2012
	PROVIDER OR SUPPLIED	R ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	10/13/11, indice required extens of daily living, in hygiene, the bit contractured a motion(ROM) is resident was a hygiene. Occur documentation discontinued or restorative states splint and ROM discharge sum resident responsible to the following start and resident responsible to the following start date of 5/1 included, but not the following start date of 5/1 included included start date of 5/1 included inclu	mpaired, and the thigh risk for hand pational therapy indicated service was n 2/1/12, and ff educated on current ff program. The mary indicated the nded to therapy and illateral static hand torative ROM program. The reviewed and collowing: eficit related to Parkinson's (problem 16/11); approaches			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155159		(X2) MU A. BUIL B. WING	DING	onstruction 00	(X3) DATE (COMPL 02/17 /	ETED	
	PROVIDER OR SUPPLIER	L R ND REHABILITATION	J. WIIW	STREET A 2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	would tolerate passive range hands and wrist warm hand so Resident reprogram (proble 2/1/2012) Appropring limited to: had signs of paunder splint; observe skin for under splint; observe skin for 4 hours 6 da Resident at breakdown due decreased mode date of 5/16/11 included, but not and document and as needed. The Certified Cassistant (COT at 9:24 a.m., or indicated she had reached splints, tolerating she had reached splints, tolerating she indicated to the splints and she indicated t	ot limited to: resident 20 repetitions of of motion to bilateral sts 6 days weekly after aks; quired splint/brace em start date of oaches included, but notify nurse if resident ain or had skin irritation or redness or irritation sident would tolerate al static hand splints ays weekly; risk for skin e to incontinence and bility (problem start). Approaches ot limited to: assess skin condition weekly Occupational Therapy TA) #2 was Interviewed in 2/16/12. She had been treating the					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155159	A. BUI B. WIN			02/17/	2012
		1	B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	3			CLINTON ST		
SUMMIT	CITY NURSING AI	ND REHABILITATION			VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the restorative	aide talked to her					
	yesterday and	informed her the					
	resident had re	fused to wear the					
	splints.						
	The COTA indi	icated while the					
	resident was in	therapy, she was able					
		nds actively enough to					
	! ·	s and she had never					
		r them before. She					
		saw the resident on					
		alking to the restorative					
		esident told her she					
	· ·	ch pain to wear the					
		dicated the resident's					
	· ·						
		odor and If necessary					
	I	her back on the					
		e indicated this was					
		ew thing with the					
		ng to wear the splints.					
		she offered to soak the					
		ds, but the resident					
		ndicated the hands					
		ter one day if the hands					
	were not soake	ed.					
	The COTA was	s observed in the					
		n, at 9:55 a.m., on					
		ng the resident's					
		sident was noted to					
		n her hands when					
		he COTA. When she					
	_	he resident's left hand,					
		dicated her hand hurt,					
		COTA opened her left					
	hand, she indic	cated there was an					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 02/17/2012			
	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	open sore in the mid palm of the left hand. The COTA indicated the resident's left thumb was contracted all the way in to the palm. At this time, the open area was observed in the middle of palm of hand where the thumb nail had been pressing. The thumb nail was also long and needed to be trimmed. The COTA indicated the area was moist and odorous. Review on the morning of 2/17/12, of the therapy screening, dated 2/16/12, and completed by COTA #2, indicated the resident had refused splint application and hand hygiene for restorative for 2 days. The COTA convinced the resident to let her clean and do passive range of motion (PROM) to the digits and wrists. Upon cleaning and performing PROM to left hand contracture, the COTA noticed a wound on the middle of the palm. Occupational therapy recommended restorative continue right hand hygiene and splint application and left orthotic use on hold until the wound healed. The note indicated nursing dressed the wound and a carrot-shaped palm protector was placed in the left hand to decrease pressure from the thumb touching the wound.						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155159	B. WIN			02/17/	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
SUMMIT	CITY NURSING AN	ND REHABILITATION			CLINTON ST VAYNE, IN 46805		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TΕ	DATE
	a pressure would report, dated 2/ stage 2, pressure Resident #2's leaded to the stage of the sta	vould be completed on the or without alterations and documented on assessment form					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 7/2012	
NAME OF P	PROVIDER OR SUPPLIEF	2	STREET A	ADDRESS, CITY, STATE, ZIP C	CODE	
SUMMIT		ND REHABILITATION		WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

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Facility ID: 000079

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155159	B. WIN			02/17/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2940 N	CLINTON ST		
	CITY NURSING AN	ND REHABILITATION		FORT V	WAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY		DATE
F0371	483.35(i)	ir.					
SS=E	FOOD PROCUR	RE/SERVE - SANITARY					
	The facility must						
	•	from sources approved or					
		factory by Federal, State or					
	local authorities;	and					
		e, distribute and serve food					
	under sanitary co						
		rvation, interview and	F03	71	What corrective actions will I	oe	03/18/2012
	record review, t	the facility failed to			accomplished for those		
	ensure staff wa	shed their hands for			residents found to have beer affected by the deficient	1	
	the appropriate	amount of time and			practice? CNA #14, #9, #15,		
	used a paper to	owel to turn off the			LPN #15 re-educated and LPN	J #	
	water faucet po	tentially affecting 9 of			15 is no longer employed at		
	9 residents who	ate in the Memory			facility.All staff in-serviced on		
	Care dining roo	om and 26 of 28			proper hand washing and prop	er	
	residents (inclu	ding Resident #26)			serving protocol to maintain		
	who ate or were	e fed their meals in the			safety and sanitary conditions while dining. How will you		
	second floor dir	ning room. The facility			identify other residents havir	na	
		nsure staff did not			the potential to be affected by	-	
		m a resident's meal			the same deficient practice a	nd	
		ingers before giving it			what corrective action will be		
	•	to eat (Resident #61)			taken? All residents served by		
		cting 1 of 4 residents			staff are at risk for this deficier	•	
		assisted dining room.			Staff will identify residents at ri daily during dining services by		
	2.0				being present in dining room a		
	Findings includ	۵:			Licensed nursing staff monitor		
		.			for any risk factors and alerting	-	
	1 During an o	bservation of the lunch			DNS/ or designee and Dietary		
		mory Care dining room			Manager. What measures will	I	
		,			be put in place or what systemic changes will you		
	on 2/13/12 at 1				make to ensure that the		
		observed seated in			deficient practice does not		
	•	re dining room. Two			recur? All staff members		
		rved passing lunch			including nursing staff and		
	trays to the res	idents. Certified			department managers will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	00	COMPLE	ETED
		155159	B. WIN			02/17/2	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			CLINTON ST		
SUMMIT	CITY NURSING A	AND REHABILITATION			VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	, 	1	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Nursing Assis	tant (CNA) #14 was			re-educated on proper hand		
		ash her hands for 15			washing techniques and servi	ng	
		did not use a paper			of food to residents by		
		• •			DNS/designee. Hand washing		
		rier when turning off the			posters to be hung in all dining		
		She directly proceeded			room sink areas. A skill check list will be conducted with each		
		trays to residents. At			staff member listed above.All	'	
	•	NA #14 was observed			Dining room services will be		
		ands for only 10			monitored by a supervisor		
	seconds and r	esumed passing lunch			schedule. Non- compliance wi	II	
	trays to reside	ents.			be monitored by DNS/ designed		
					and follow up appropriately. Ho	ow	
	2. During an o	bservation of the lunch			will the corrective action be		
	meal in the se	cond floor dining room			monitored to ensure the		
		12:25 p.m., three facility			deficient practice will not rec	ur	
		erved passing lunch			and what quality assurance program will be put in place?	, _	
		residents who ate their			CQI hand washing Log will be		
	· ·	econd floor dining			monitored by DNS/designee th	nat	
		assing several lunch			will monitor the daily x 1 montl		
		was observed to wash			twice weekly x 3 months, and		
	1				weekly x3 months, and then		
		5 seconds and did not			quarterly until cotinued		
		owel as a barrier when			compliance is maintained for t consecutive quarters.Data will		
	_	water faucet. She			submitted to CQI committee for		
		eded to feed Resident			review and follow up.To ensur		
	#26 who requi	ired total assistance at			compliance. The results will be		
	mealtime.				reviewed by CQI committee		
					overseen by the ED. If thresho		
	3. During an o	bservation of the lunch			of 95% is not achieved an acti		
	meal in the as	sist dining room on			plan will be developed to ensu compliance.Non compliance n		
		10 p.m., LPN #15 was			result in disciplinary action up		
		ling Resident #61 who			and including termination.	.	
		assistance at mealtime.			J		
As indicated on review of the							
	Fall/Winter 2011-2012 menu for that						
	· ·	dent received oven					
	browned potat	toes. LPN #15 was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S		
		155159	A. BUI B. WIN	LDING G		02/17/	
	PROVIDER OR SUPPLIER	ND REHABILITATION	p. (VII.)	STREET A	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	observed to pi browned potate fingers and pla resident's spoor spoon into the She was also or bare fingers to browned potate spoon before puthe mouth of the The Assistant I interviewed on During the interviewed on During the interviewed on During the interviewed to faucet prior to a meal trays. She were not to use handle food the residents. A facility policy & Procedure, " indicated " To infectious disease.	ck up individual oven bes with her bare ce then on the on before placing the mouth of the resident. Observed to use her push the oven bes onto the resident's olacing the spoon into the resident. Director of Nursing was 2/16/12 at 1:37 p.m. rview, she indicated nel were to wash their econds and use a turn off the water assisting residents with the also indicated staff the their bare hands to at was served to the "Hand Washing Policy dated 1/2010, prevent the spread of aseWhen washing			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE .	
	hands first with	ip and water, wet water, apply soap and other vigorously for at					
	least 20 second surfaces of the Rinse hands w thoroughly with	dscovering all hands and fingers. ith water and dry n a disposable towel. rn off the faucet"					

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	00		
SUMMIT	ROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP COI CLINTON ST NAYNE, IN 46805	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	3.1-21(i)(2)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/17/2012
	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review, and interview, the facility failed to ensure pharmacy and nursing policies were implemented to ensure medications were administered as ordered by the physician for 1 of 24 residents reviewed for following orders in a stage 2 sample of 27 residents (Resident #36). Findings include: The record for Resident #36 was reviewed on 2/14/12 at 2:00 P.M. Diagnoses included, but were not limited to, psychosis.	F0425	What corrective actions will accomplished for those residents found to have been affected by the deficient practice? Resident # 36 medications were reviewed ar discontinued by MD at the time that the deficiency was noted. The resident's Care Plan was reviewed and updated as needed. The DNS reviewed the error with the staff member that failed to capture medication change at the time of admissional charts were reviewed to compare physician orders with Medication and treatment recorder accuracy. How will you identify other residents having the state of the second se	nd ee ne at on.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805 (X4) ID PREFIX TAG A physician's order, dated 12/9/11, indicated Seroquel (medication used to treat psychosis) was increased from 25 mg (milligrams) in the morning and 50 mg at bedtime to 50 mg twice daily (morning and bedtime). The Medication Administration Record (MAR) for Resident #36 for December 2011 indicated the order was STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805 ID PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DOBRICIANCY) PREFIX TAG The Medication Administration Record (MAR) for Resident #36 for December 2011 indicated the order was STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805 ID PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DOBRICIANCY) PREFIX TAG The Providers PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DOBRICIANCY) TAG The Providers PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDERS PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDER PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDER PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY) TAG THE PROVIDER PLAN OF CORRECTION (CASS REFERENCED TO THE APPROPRIATE DEPCIANCY T
NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A physician's order, dated 12/9/11, indicated Seroquel (medication used to treat psychosis) was increased from 25 mg (milligrams) in the morning and 50 mg at bedtime to 50 mg twice daily (morning and bedtime). The Medication Administration Record (MAR) for Resident #36 for December 2011 indicated the order was STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805 ID PROVIDERS PLANOF CORRECTION (CASHI CORRECTION SHOULD BE GROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) TAG PREFIX TAG PREFIX PROVIDERS PLANOF CORRECTION (CASHI CORRECTION SHOULD BE GROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) TAG The potential to be affected by the same deficient practice and what corrective action will be taken? All residents are at risk for deficiency. Staff will be educated on the proper transcription process and the Monthly Rewrite process. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? DNS/designee will re-educate nurses on re-write
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The Medication Administration Record (MAR) for Resident #36 for December 2011 indicated the order was you make to ensure that the deficient practice does not recur? DNS/designee will re-educate nurses on re-write
Record (MAR) for Resident #36 for December 2011 indicated the order was deficient practice does not recur? DNS/designee will re-educate nurses on re-write
December 2011 indicated the order was recur? DNS/designee will re-educate nurses on re-write
2011 indicated the order was re-educate nurses on re-write
changed on 12/9/11 to Seroguel 50 process. All licensed nursing staff
will be in serviced on now
mg twice daily. mg twice daily. protocol. A post test will be given
during in-service. How will the
The MARs for January 2012 and corrective action be monitored
February 2012 indicated the resident to ensure the deficient practice
was to receive Seroquel 25 mg in the will not recur and what quality
morning and 50 mg at bedtime. assurance program will be put
in place? A CQI Medication
Nurse #24 was interviewed on Transcription Log will be
morniored daily x 1 mornin, twice
2/15/12 at 9:15 A.M. During the weekly x 2 months, and weekly
interview, the nurse indicated x3 months, ending with periodic
Resident #36 was to receive Seroquel checking as needed for
25 mg in the morning and 50 mg at compliance by DNS/designee.Monitoring will be
bedtime. The nurse provided done daily by nursing
Resident #36's Seroquel packages management team to verify new
from the medication cart. The labels orders are faxed and processed
on the packages indicated the dose of by pharmacy correctly. Data will
be submitted to COI committee
the Seroquel tablets as 50 mg. One for review and follow up on a
package contained whole tablets of monthly basis. The ED will be
Seroquel and one package contained responsible CQI committee
tablets that had been cut in half. The
instructions on the labels indicated achieved an action plan will be
the resident was to be administered a

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
	155159	B. WING		02/17/2012
N. 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	DROUDER OR GURN IER		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		CLINTON ST	
SUMMIT	CITY NURSING AND REHABILITATION		WAYNE, IN 46805	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	I	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	half tablet (25 mg) of Seroquel in the		compliance. Non compliance	mav
	morning and a whole tablet of		result in disciplinary action up	-
	Seroquel (50 mg) at bedtime.		and including termination.	
	Seroquer (30 mg) at bedtime.			
	The facility Assistant Director of			
	1			
	Nursing (ADON) was interviewed on			
	2/15/12 at 9:45 A.M. During the			
	interview, the ADON indicated			
	Resident #36 had previously been			
	prescribed Seroquel 25 mg in the			
	morning and 50 mg at bedtime, but			
	the order had been changed by the			
	physician to Seroquel 50 mg twice			
	daily on 12/9/11. The ADON further			
	indicated the order had been changed			
	to Seroquel 50 mg twice daily on the			
	December 2011 MAR, but the change			
	had not been carried over to the			
	January 2012 and February 2012			
	MARs. The ADON indicated the			
	January 2012 and February 2012			
	MARs should have been checked by			
	nursing staff and compared to the			
	orders in the chart to ensure all of the			
	orders were accurate. The ADON			
	indicated she did not know why			
	pharmacy had continued to send the			
	wrong dose of the Seroquel to the			
	facility and could not indicate if			
	nursing staff had notified the			
	pharmacy of the order change.			
	An undated facility policy entitled			
	"Medication Administration" was			
	provided by Nurse #7 on 2/17/12 at			
	<u> </u>			

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	of correction identification number: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLET 02/17/20	TED
	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	STREET . 2940 N	ADDRESS, CITY, STATE, ZIP C CLINTON ST WAYNE, IN 46805	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	11:00 A.M. The policy indicated "The MAR (medication administration records) are to be verified with the physician's orders at least monthly."				
	3.1-25(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPLE	
		155159	B. WING			02/17/2	2012
NAME OF P	PROVIDER OR SUPPLIER	t			DDRESS, CITY, STATE, ZIP CODE		
CHAMAIT	CITY NILIDSING AN	ND REHABILITATION			CLINTON ST /AYNE, IN 46805		
					VATNE, IN 40003		
(X4) ID		TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	ì ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX AG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION DATE
F0456	483.70(c)(2)	ESC IDENTIFY TING INFORMATION)	17	AU			DATE
SS=D		UIPMENT, SAFE					
00 5	OPERATING CO						
	The facility must	maintain all essential					
		ctrical, and patient care					
	i i	fe operating condition.					
	Based on obse	rvation, interview, and	F0456		It is the intent of this communit	,	03/18/2012
		the facility failed to			to have all essential equipmen safe and in operating condition		
	ensure call ligh	ts in resident rooms			What corrective actions will I		
	were functioning	ig for 2 residents in a			accomplished for those		
	sample of 40 re	esidents reviewed for			residents found to have been	1	
	call light function	on. (Resident #1 and			affected by the deficient		
	Resident #44)				practice? The call light outside	е	
	ŕ				room 211 was replaced and		
	Findings includ	e:			verified in working order after		
					replacement by the maintenan and nursing department. The o		
	1. The call ligh	its for the beds in			light cord and call button for	Jan	
	_	211, where Resident			resident # 44 was replaced at	the	
		nt #44 resided, were			time of notification. The		
		oper functioning at			maintenance department verifi		
		2/13/12. Both of the			that it was in working order are easy for the resident to operate		
	· ·	on the light indicator			How will you identify other	е.	
	1 -	ne residents' room:			residents having the potentia	al I	
		all light indicator above			to be affected by the same		
		e of the residents'			deficient practice and what		
		aht up when the call			corrective action will be		
	· ·	•			taken?Nursing staff will check		
	lights were acti	val c u.			call lights daily x 3 month, week	KIY	
	The emerge	v call light in the			x 3 months and then quarterly until compliance is maintained	for	
		y call light in the			2 consecutive quarters. What	.5.	
		room also lit up in the			measures will be put in place	,	
	· ·	did not light up above			or what systemic changes wi		
		e of the residents'			you make to ensure that the		
	room. LPN #19				deficient practice does not		
		n, at 11:50 A.M., on			recur? The director of		
	· ·	dicated she was in the			Maintenance will conduct an in-service for all staff regarding	,	
	nurse's station	(located on the other			in-service for all staff regarding	9	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155159	B. WIN			02/17/2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	
SUMMIT	CITY NURSING A	ND REHABILITATION			CLINTON ST VAYNE, IN 46805	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	equipment in safe operating or	DATE
		he panel in the nurse's idicating the call light			and the importance of notifing	dei
		vated in Room 211. The			management when it is not. H o	ow
		d the light indicator			will the corrective action be	
		or on the outside of the			monitored to ensure the	
					deficient practice will not rec and what quality assurance	ur
		ght up when the call om were activated and			program will be put in place?	,
	she would have				The maintenance director and	
	Sile Would Hav	o it officiated.			appointment staff member will	
	In addition the	e call light for Resident			conducting weekly verification	
		difficult to turn on and			all call lights to ensure that the all are in working order. This w	-
	1	ressed several times			be part of the weekly preventa	
	before the ligh				maintenance program as well	as
					the safety program.DNS/desig	
	Review of the	February 2012 "Verify			will use the Call Light CQI Too ensure compliance with daily or	
		ion" forms, provided by			light system functionality check	
		Director of Nursing			Data will be submitted to CQI	
		/16/12, at 12:16 P.M.,			committee for review and follo	w
		nurse call system was			up monthly.The ED will be	
		6/12 and 2/13/12 for			responsible CQI committee audits. If threshold of 100% is	not
	proper function	ning.			achieved an action plan will be	
	' '	G			developed to ensure	
	Maintenance /	Assistant #18, was			compliance. Non compliance r	-
	interviewed, o	n 2/17/12, at 9:50 A.M.,			result in disciplinary action up and including termination.	io
	and indicated	the bulb was replaced			and moldaring termination.	
		indicator outside the				
	residents' doo	r.				
	3.1-19(bb)					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155159	A. BUILDING	00	02/17/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	32, 11, 23 12
NAME OF P	PROVIDER OR SUPPLIER			CLINTON ST	
		ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1710	REGGENTORT OR	LESC IDENTIFIEND INFORMATION)	IAG		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	ETED
		155159	B. WIN			02/17/2	2012
			D. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				CLINTON ST		
SUMMIT CITY NURSING AND REHABILITATION		ND REHABILITATION			VAYNE, IN 46805		
			_		, IIV 40000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES	4DL ETE (4.00LID 4 TE (4.00E					
		IPLETE/ACCURATE/ACCE					
	SSIBLE	maintain clinical records on					
	-	accordance with accepted					
		ndards and practices that are					
		ately documented; readily					
		systematically organized.					
		, , , , , , , , , , , , , , , , , , , ,					
	The clinical reco	rd must contain sufficient					
	information to ide	entify the resident; a record					
		assessments; the plan of					
		s provided; the results of any					
		reening conducted by the					
	State; and progre						00/10/0010
	Based on recor	d review, and	F05	14	What corrective actions will I	ре	03/18/2012
	interview, the fa	acility failed to ensure			accomplished for those		
	medication orde	ers were correctly			residents found to have beer	1	
	transcribed on	to the Medication			affected by the deficient		
	Administration	Record (MAR) for 1 of			practice? Resident # 36 medications were reviewed an	,	
		viewed for transcription			discontinued by MD at the time	-	
		•			that the deficiency was noted.	, I	
		otal sample of 27			The resident's Care Plan was		
	residents (Resi	dent #36).			reviewed and updated as need	ded.	
					DNS reviewed error with the s		
	Findings includ	e:			member that failed to capture		
					medication change at admission	on.	
	The record for	Resident #36 was			All charts were reviewed to		
	reviewed on 2/	14/12 at 2:00 P.M.			compare physician orders with		
	Diagnoses incli	uded, but were not			Medication and treatment reco	ords	
	limited to, psyc				for accuracy. How will you		
					identify other residents having	-	
	A physisian's s	rdor dated 12/0/11			the potential to be affected by the same deficient practice a		
		rder, dated 12/9/11,			what corrective action will be		
		quel (medication used			taken? All residents are at risk		
	' '	sis) was increased			for deficiency. All nursing staff		
	from 25 mg (mi	lligrams) in the			be re-educated on proper		
	morning and 50	mg at bedtime to 50			transcription process and the		
		-			Monthly Rewrite process Wha	. l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155159	A. BUILDING B. WING 02/17/2012				
		1	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R			CLINTON ST		
SUMMIT	CITY NURSING AI	ND REHABILITATION			WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	mg twice daily	(morning and bedtime).			measures will be put in place		
					or what systemic changes w you make to ensure that the	!!!	
		n Administration			deficient practice does not		
	Record for Res	sident #36 for			recur? DNs/designee will		
	December				re-educate nurses on re-write		
	2011 indicated	the order was			process. All licensed nursing s	staff	
	changed on 12	2/9/11 to Seroquel 50			will be in-serviced on new		
	mg twice daily.	- -			protocol. A post test will be give		
					during in-service. How will the		
	The MARs for	January 2012 and			to ensure the deficient practi		
		did not reflect the			will not recur and what quali		
		ers and indicated the			assurance program will be p	- I	
		receive Seroquel 25			in place? A CQI Medication		
		ning and 50 mg at			Transcription Log will be		
	bedtime.	ing and 50 mg at			monitored daily x 1 month, twi		
	Dealine.				weekly x 3 months, and weekl	-	
	The feether Ass	sistent Dineston of			x3 months, ending with quarte	erly	
		sistant Director of			checks until continued contininued compliance is		
		N) was interviewed on			maintained for 2 consecutives	,	
		A.M. During the			quarters. Monitoring will be do		
		ADON indicated			daily by nursing management		
		nad previously been			team to verify new orders are		
	·	oquel 25 mg in the			faxed and processed by		
	1	0 mg at bedtime, but			pharmacy correctly. Data will I submitted to CQI committee for		
	the order had b	peen changed by the			review and follow up monthly.		
	physician to Se	eroquel 50 mg twice			ED will be responsible CQI		
	daily on 12/9/1	1. The ADON further			committee audits. If threshold	of	
		rder had been changed			95% is not achieved an action		
		mg twice daily on the			plan will be developed to ensu		
	•	1 MAR, but the change			compliance. Non compliance		
		carried over to the			result in disciplinary action up and including termination.	io	
		and February 2012			and moduling termination.		
	,	DON indicated the					
		and February 2012					
	1	nave been checked by					
		-					
	i nursing statt af	nd compared to the	1		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/17/2012	
	PROVIDER OR SUPPLIE	R ND REHABILITATION	STREET 2 2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	orders in the o	hart to ensure all of the ccurate.			
	"Medication A provided by N 11:00 A.M. Th MAR (medicat records) are to	cility policy entitled dministration" was urse #7 on 2/17/12 at ne policy indicated "The ion administration be verified with the ders at least monthly."			

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